Form Approved
OMB No. 0920-0017
Exp. Date 3/31/2000

Registration Form
Select Agent Rule

Please type or print			
(Dr., Mr., Mrs., Ms., or Miss)	(First)	(M.I.)	(Last)
Social Security Number		We also need to know your Social Security Number. This number is voluntary and collected under the Public Health Service Act.	
Position Title		E-mail address	
Employer's Name		Employer's Phone Number	
Employer's Address		Employer's Fax Number	
City	State	Zip	
Course No. & Date: June 22, 2000		Location: Satellite Broadcast	

(Signature of Applicant Date

OCCUPATION
(Circle one number)

01 Physician
02 Veterinarian
04 Laboratorian
05 Nursing
06 Sanitarian
07 Industrial Hygienist
08 Administration
09 Water Treatment Operator
11 Safety Professional

EDUCATION LEVEL
(Circle Highest Level Attained)

01 Some High School
02 High School Graduate
03 Some College
04 Associate's Degree
05 Bachelor's Degree
06 Master's Degree
07 Doctoral Degree-MD
08 Doctoral Degree-Other than MD
09 Technical/Hospital School
10 Other _____

TYPE OF EMPLOYER
Please review all categories before circling appropriate one
(Circle one number)

01 State and Territorial Health Department
02 Other State & Territory Employer
03 Local, City or County Health Dept.
04 Other Local Government Employer
05 CDC
06 Other CDC Employer
09 U.S. Food & Drug Administration
11 U.S. Department of Defense
12 Veteran's Administration Hospital
15 Other Federal Government Employer
16 Foreign Employer
17 Private/Community Hospital
19 College/University
21 Private Industry
23 Private Clinical Laboratory
24 Physician Office Lab/Group Practice
25 Hospital-State Funded
26 Hospital-City/County Funded
28 Health Maintenance Organization

Please submit this registration form by mail or FAX to:

National Laboratory Training Network
Southeastern Office
P. O. Box 160385
Nashville, TN 37207-8215

FAX: 615-262-6441

THE FOLLOWING PRIVACY ACT STATEMENTS IS APPLICABLE TO ALL INCLUDED FORMS NEEDING SOCIAL SECURITY NUMBER

The information requested on this form is collected under the authority of 42 U.S.C. 243. The requested information is used only to process and evaluate your application for training and may be disclosed (for verification purposes) to your employer, group leader, educational institution, etc. as necessary. An accounting of such disclosures will be furnished to you upon request. Furnishing the information requested on this form, including your Social security number (SSN), is voluntary. However, no applicant may receive Continuing Education Unit or Continuing Medical Education Unit credit unless a completed application form is received. The SSN is used for identity verification purposes and prevents the assignment of more than one identifying number to the same individual. If you do not wish to submit a SSN, CDC will assign a unique identifier.

Public Reporting burden for this information is estimated to average 5 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC-ASTDR Reports Clearance Officer, 1600 Clifton Road, N.E., MS d-24, Atlanta, Georgia 30333; Attn: PRA (0920-0017).